Print Form

Banner Pediatric Specialists

☐ New Patient ☐ Follow Up

Patient Information					
Name (Last, First, Middle):			DOB:	Sex:	Social Security Number:
Street Address:			City, State, Zip		Home Phone:
Primary Care Physician: Phone:			Referred By: Phone:		

Parent/Guardian Information:					
Name (Last, First, Middle):			Name (Last, First, Middle):		
SSN#:	DOB:	Relationship to Patient:	SSN#:	DOB:	Relationship to Patient:
Street Address:			Street Address:		
City, State, Zip	Home Phone:		City, State, Zip	Home Phone:	
Work Phone:	Cell Phone:		Work Phone:	Cell Phone:	
Email:			Email:		

Primary Insurance:			
Name of Insurance Company:		Name of Insured (Last, First, Middle):	
Policy #:	Group #:	Employer:	
Claims Mailing Address:		Employer Address:	
City, State, Zip:	Phone #:	City, State, Zip:	Phone #:

Secondary Insurance:			
Name of Insurance Company:		Name of Insured (Last, First, Middle):	
Policy #:	Group #:	Employer:	
Claims Mailing Address:		Employer Address:	
City, State, Zip:	Phone #:	City, State, Zip:	Phone #:

Emergency Contact:			
Name (Last, First, Middle):		Relationship to Patient:	
Home Phone:	Cell Phone:	Work Phone:	Alternate Phone:

I authorize payment of benefits to Banner Health for professional services rendered. This is a direct assignment of benefits of my rights and benefits under my insurance policy. I authorize the release of all medical information necessary to process my claims. I authorize direct payment of benefits from my insurance company. I understand that I am responsible for any unpaid balance for services received but not covered under my insurance policy. By also signing below, I hereby acknowledge that I have received a Notice of Privacy Policy.

A separate release is required for release of copies of records. May we leave a message on your voicemail at home and cell?
☐ Yes ☐ No

_____ _____

Signature of Parent / Guardian Date